

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

2546

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO.	SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

James M. Kelley

**USE BLACK INK
OR
TYPEWRITER RIBBON**

HEALTH AND WELFARE Registration District No. <u>149</u> Primary Registration District No. <u>1002</u> Registrar's No. <u>2546</u> STATE FILE NUMBER	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY, MISSOURI</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VA HOSPITAL</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> d. STREET ADDRESS (If outside, give location) <u>8301 EAST 55TH</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>RAMSEY</u> <u>MCKENZIE</u>	
4. DATE OF DEATH Month Day Year <u>MAY</u> <u>1</u> <u>1963</u>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>4-21-93</u> 9. AGE (last birthday) <u>70 YRS</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SAFETY</u> 11. BIRTHPLACE (City and state or country) <u>JEFFERSON CITY, MO</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN MCKENZIE</u> 13b. MOTHER'S MAIDEN NAME <u>MARY ABBOTT</u> 14. NAME OF HUSBAND OR WIFE <u>MARY MCKENZIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u> 16. SOCIAL SECURITY NO. <u>VA HOSPITAL OFFICIAL RECORDS</u> 17. INFORMATION FROM ADDRESS <u>VA HOSPITAL OFFICIAL RECORDS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EMPHYSEMA</u> DUE TO (b) <u>CHRONIC BRONCHITIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____ 20c. TIME OF INJURY Hour _____ Month _____ Day _____ a.m. _____ p.m. _____ 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>APRIL 21, 1963</u> to <u>MAY 1, 1963</u> and <u>4/21/63 to 5/1/63</u> Death occurred at <u>2:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>James M. Eyllar</u> M. D. <u>VA HOSPITAL, KANSAS CITY, MO</u> 22b. ADDRESS _____ 22c. DATE SIGNED <u>MAY 1, 1963</u>	
23a. BURIAL, CREMATION, or DISPOSAL (specify) <u>Burial</u> 23b. DATE <u>5-3-1963</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Brooking Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mellody-McGilley-Eylar 20 W. Linwood</u> 25. DATE RECD. BY LOCAL REG. <u>5-1-63</u> 26. REGISTRAR'S SIGNATURE <u>Ruth Sosa</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lloyd F. Dieckman

Licensed Embalmer No. 5120

P. O. Address K.C. 11/2 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.